Related Public Policies Affecting the TDH Hospitals

Related Government Issues

A Binational Approach to Public Health

The Texas-Mexico border is an area defined by social, cultural, economic, and even linguistic interdependence. The Mexican adage, "Mexico develops pneumonia when the United States sneezes," is accentuated along a border that remains porous despite the best efforts of the U.S. Immigration and Naturalization Service (INS). The populations of our five border states dine in each other's restaurants, shop at each other's stores, watch and listen to each other's media, visit their families on either side of the border, and speak the same language.

An international border is not only no barrier to disease, it exacerbates the effectiveness of disease control and prevention by interrupting the long-care treatment necessary to cure chronic diseases and, in the case of infectious diseases, by disrupting the abilities of public-health authorities to conduct thorough investigations of patient contacts. A coordinated, binational approach is logical given these challenges and the fact that the United States and Mexico share similar public health issues. Examples of shared problems include infection with hepatitis, Dengue, and human immunodeficiency virus, as well as environmental dangers such as those affecting the supply and quality of potable water and the existence of adequate waste-water disposal systems. The most pressing threat to public health shared by our two countries, however, may well be tuberculosis.

The border poses significant barriers to effective tuberculosis control. Although the people and the disease behave as if sister-cities such as Brownsville and Matamoros are a single community, the existence of separate tuberculosis control programs on each side of the border creates unique difficulties: some cross-border contacts to cases are not examined; treatment cannot be monitored continuously; and, treatment regimens may be changed when a case moves across the border. Separate policies and laws related to tuberculosis add to the difficulties in controlling this disease. For example, until recently the drug, rifampin, the cornerstone in the treatment of active tuberculosis, was available without prescription in Mexico. Use of this drug outside of a medically controlled setting can result in development of resistant organisms and the loss of efficacy of this critical agent. Thus, the result of separate tuberculosis policies and control programs is higher rates of tuberculosis on the border and a higher incidence of drug resistant tuberculosis on the border.

Tuberculosis rates for many Texas-Mexico border communities exceed the rates found both in the interiors of their states as well as the U.S. and Mexico national rates. In 1995 when the TB rate for the U.S. stood at 8.7 per 100,000 population and Mexico's rate at 12.1 per 100,000 population, Texas and its neighboring Mexican states reported elevated rates of disease, such as 24.0 in McAllen, 33.0 in Brownsville, 16.0 in El Paso, 53.0 in Reynosa, 37.0 in Matamoros, and 26.0 in Ciudad Juarez.

The impact of TB in Mexico reaches beyond the Texas-Mexico border states. In 1996,

individuals born in Mexico represented 18 % of all Texas TB cases and 60% of all foreign-born cases reported in Texas that year. This high number of Mexican-born individuals among Texas TB cases is not just a matter of geographic proximity; it is also a reflection of the endemic nature of tuberculosis in Mexico: of the 13 countries responsible for approximately 75 percent of the world's TB cases, Mexico ranks ninth, reporting approximately 56,200 *new* cases each year. In addition, more people in Mexico die from TB than from any other infectious disease. The fact that the proportion of foreign-born TB cases in Texas is on the rise, comprising almost one-third of all TB cases in our state in 1996, underscores the sobering reality that diseases respect no borders and validates the wisdom of transnational coordinated public health efforts.

For reasons cited earlier — interruption of therapy, unavailability of drugs, overuse and abuse of antituberculous agents — the Texas-Mexico border is home to an increasing number of cases not susceptible to the most efficacious TB drugs. Eight of Texas' 21 MDRTB cases (38% of total) were reported from seven border counties that comprise less than three percent of the state's population. A full 86% of MDRTB cases were among people born in countries other than the United States, two thirds of whom named Mexico as their country-of-origin. One of the most disturbing recent findings is that over 200 MDRTB cases have been identified in Matamoros and Reynosa since 1994. A search of Mexican vital statistics indicates that nearly all of these cases are still alive, potentially spreading their disease to others in the community.

Several demographic characteristics and trends converge along the Texas-Mexico border to make the prevalence of tuberculosis higher and the treatment of or control of TB more difficult there than in most other parts of either country:

> ***Exploding population growth*. This is particularly true on the Mexican side, driven in part by the employment magnet produced by a proliferation in the number of *maquiladoras* (predominantly foreign-owned plants that assemble manufactured goods for eventual export into the U.S.) in its six border states. Of the approximate 3,500 maquiladoras in Mexico, 28% are located in Chihuahua, Coahuila, Nuevo León, or Tamaulipas — 67% of which are located right on the Texas-Mexico border.**
>
> **If the growth rate continues at its current pace, the U.S. border population will double in half the time it takes the country's population as a whole to double (i.e., 45 vs 90 years); in Mexico, the border population will double in nine years versus 24 years for the nation as a whole. Not only will this exacerbate the difficulties in controlling tuberculosis, but the existing public-health infrastructure, if financed at current levels, may collapse under the pressures placed upon it by this surge in population.**
>
> ***Unique demographics of the border population*: The youthfulness of the semi-skilled laborers drawn to the maquiladoras and of the border population overall (over half are 25 years-of-age or under) heightens the risk of other conditions associated with this younger age group (e.g., HIV/AIDS, substance abuse, sexually transmitted diseases). Co-existence with any of these other conditions can serve to worsen the course of TB, make the disease more difficult and costly to treat, and require a level of clinical expertise lacking in most border communities. Finally, if world-wide mortality trends**

are applicable locally, the fact that more than 75 percent of maquiladora employees are women is also worrisome: tuberculosis is *the* leading killer of women around the world, depriving more children of their mothers than any other infectious disease.

Highly mobile populations: **The U.S.-Mexico border is considered one of the world's busiest with respect to human traffic. This mobility is fueled by frequent border crossings, dual residences, commerce, and seasonal/migratory employment. Of the five INS districts along this international border, three are located in Texas and in 1996 accounted for 166 million of the 281 million (i.e., 59%) *legal* north-bound crossings alone. The implementation of NAFTA will not only accelerate this trend, but will cause disease transmission to penetrate more deeply into the interior of the state and beyond.**

***Isolation of most border populations*: With the exception of key sister-cities (e.g., El Paso-Cd. Juárez, McAllen-Reynosa, Harlingen-Brownsville-Matamoros), most of the binational border population is dispersed in remote areas and under-served from a health-care availability and delivery standpoint. Furthermore, the services that do exist are either difficult to deliver to those in need, or a hardship for patients to access. Because TB is only cured when medication is taken on a consistent basis over a period of months, any impediments to accessing or delivering TB medications represent more than an inconvenience: such impediments guarantee that the patient will not be cured, will continue to expose others to the disease, and will increase the risk of the development and transmission of drug-resistant strains of the disease.**

***Poverty on the border*: Although Mexico's six border states are relatively prosperous when compared to most of the country's other states and territories, a majority of this population lives in conditions of poverty and is at heightened risk for contracting diseases associated with poverty, among which TB is significant. Poverty is no stranger to Texas' border either. According to 1990 figures, Texas border counties are among the poorest in the United States, as evidenced by the following percentages of people living below the poverty line:**

United States	**13%**
Texas	**18%**
Brownsville	**44%**
Eagle Pass	**46%**
El Paso	**32%**
Laredo	**37%**
McAllen	**33%**

Given the realities painted by demographic and epidemiologic data, the need for binational collaboration in approaching public-health issues is obvious: by way of analogy, it is the third leg that steadies and strengthens a two-legged table. Such collaboration validates the principle of interrelatedness and recognizes the need to incorporate this principle into solutions. Since the early 1990s, the Texas Department of Health has successfully engaged federal, state, and

local public-health authorities in Mexico in binational collaborations aimed at addressing the unique challenges to tuberculosis posed by the cross-border patient.

On the federal and state levels, Ten Against TB (TATB), a binational TB control and prevention effort led by the 10 US and Mexican border states, has identified the key issues surrounding the problem of cross-border TB as well as articulated both countries' plan for addressing the matter. It is based upon the premise that two nations working together can accomplish victories in public-health not possible if each country acts alone. Among its most lasting legacies is the surge in the frequency and quality of communications between Mexican and U.S. public-health authorities and their openness and commitment to the concept of binational collaboration.

Project JUNTOS, Los Dos Laredos, and Grupo Sin Fronteras are binational sister-city TB projects whose purpose is to "direct resources to areas of need and develop effective channels of communication and cooperative working relationships among professionals managing tuberculosis control and prevention programs on both sides of the Texas-Mexico border." The projects provide diagnostic, treatment, and outreach services for the cross-border patient and his/her contacts as well as opportunities to train health-care providers and educate the general public. The most successful of these programs has been integrated into the local Mexican tuberculosis control program. Although a direct cause-and-effect relationship cannot be determined, the rates of tuberculosis have dropped faster in our border counties than in our large cities since these programs came into existence. However, in spite of this faster decline, border tuberculosis rates remain nearly twice the state-wide rate.

Even if one assumes that the existing programs have been effective and are responsible for the rate of decline in TB cases along the border, the partners in these collaborations still perform as separate, independent entities. Thus, policies, procedures, and capabilities vary across the border. As discussed previously, this leaves the door open for continued transmission of drug resistant and drug susceptible disease.

Opportunities for binational collaboration include but are not limited to:

<u>Basic Research and Clinical Care</u>

Standardization of treatment regimen for active tuberculosis
Prevalence of MDRTB
Optimal therapy for MDRTB

<u>Epidemiology, Surveillance and Disease Reporting</u>

Accurate counting of cases
Full and complete contact investigation

<u>Health Care Delivery</u>

Implementation of Directly Observed Therapy (DOT)
Availability of Trained Health Care Workers
Availability of Therapeutic Agents

Overarching Needs

Coordinated Public Education
Health Care Infrastructure
Creation of Compatible Electronic Communication Systems
Incompatibility of Centralized vs. Decentralized Structures

The unique characteristics of the U.S.-Mexican border pose particular challenges to the delivery of public-health services in this region. Shared public health concerns affecting a population that moves freely on both sides of the border support the need for binational cooperation in achieving the goal of improved public health. Tuberculosis is a major problem in this region; as such, binational models developed to better deliver care for this disease may prove useful in responding to other public health issues such as re-emerging infectious diseases.

CDC-Designated Centers of Excellence

The Centers for Disease Control and Prevention (CDC) has funded four centers in California, Colorado, New Jersey, and New York City, and expressed a continuing interest in the development of regional centers of excellence in control of tuberculosis. A unified effort that a state such as Texas could have between the Texas Department of Health and an academic component such as UTHC-Tyler could offer the best possible scenario for combining clinical care, education, and research in combating the spread of this disease. If properly postured, the expertise of the Texas Department of Health linked with those academic areas of clinical management, research and education, will provide a strong argument for Texas to receive designation as one of the centers of excellence, which would provide a regional source of referral, stimulus for unique research endeavors and grant funding, and access to CDC-funded assistance for research and education. By forming the TDH/academic alliance, all of the integral components ranging from basic science research, clinical management, education, continuing education, and laboratory support would be available.

Immigration Reform Legislation

New categories related to public benefits where established in 1996 changes in federal law. Bans on "federal public benefits" and "federal means-tested benefits" for immigrants have exceptions for:

- **Emergency Medicaid**
- **Immunizations**
- **Diagnosis & Treatment of Communicable Disease**

While the communicable disease services will continue to be available in Texas regardless of immigrant status, when rules are promulgated by which citizenship will be addressed by state agencies, medical, surgical and support services at TCID and STH will be affected. Because no rules require proof of citizenship for the patients currently treated at the TDH Hospitals, no estimates are available for the human impact of loss of benefits when state rules are implemented.

Regional Academic Health Center (RAHC) for the Lower Rio Grande Valley

The 75th Legislature of the State of Texas passed Senate Bill 606 which was codified as Texas Education Code Sections 74.611-74.615 (Vernon Supp. 1997) authorizing the University of Texas to create a regional academic health center (RAHC) within a four county area including Cameron, Starr, Hidalgo, and Willacy counties in the Lower Rio Grande Valley. The University anticipates that the RAHC will be accomplished through a community-based effort led by University to develop an educational center committed to excellence and composed of: (1) accredited clinical education programs in medicine, perhaps other health professions and (2) accredited graduate physician (resident) education programs with full-time, part-time and volunteer faculty. It is anticipated that the RAHC will become a center for development of clinical education programs providing distinctive clinical experiences in required and elective clerkship unique to the Lower Rio Grande Valley.

The University's primary goal is to establish a RAHC that meets all accreditation requirements necessary to provide two years of clinical education for medical students and to qualify as an accredited geographically-separate clinical campus. Accreditation requirements specify that the education of medical students must occur in an environment of approved residency programs in specified primary care disciplines. The RAHC will be supervised by and accountable to one of University's existing medical schools. The 75th Texas Legislature authorized the issuance of $ 30 million in revenue bonds beginning in State Fiscal Year 1999 for construction of a facility or facilities for the RAHC. The Texas Legislature also appropriated $1.3 million for operation of the RAHC and $1.05 million for debt service on the RAHC beginning in State Fiscal Year 1999. A consulting group was retained by the UT System to conduct the site selection process. That process is currently on-going with first due dates in July, 1998 from interested Valley cities. The firm will advise the Board of Regents on the best site for the health center. The regents anticipate making a decision on the site by Spring, 1999.

The RAHC evaluation is significant to STH services in several ways:

- **STH is currently the only political subdivision with a four county authorization for provision of health care services (HSC, Ch. 13.003) in the Lower Rio Grande Valley. Its authority could be transferred to another governmental unit so that four-county eligibility systems could be developed.**
- **RAHC selection criteria requires evidence of full financial support of resident training**

programs in accordance with the appropriate accreditation standards, including funding in support of uncompensated patient care services. Program funding for current STH services could be anticipated to be transferred to RAHC affiliates.

- **The STH site could be considered as a clinical campus for RAHC activities; could be transferred either to a UT-System medical education center or local authority for use by RAHC programs; or could be considered for its long term property value for sale in support of future RAHC programs.**

Shared Campus Facilities with TDMHMR

The Texas Department of Mental Health and Mental Retardation has an ongoing contract with R. G. Vanderweil Engineers, Boston Massachusetts to provide the following:

- **Computer Aided Facility Management System (CAFM**
- **Computerized Maintenance Management System (CMMS)**
- **Facilities Conditions Assessment on each TDMHMR facility, statewide**

This contract is for an evaluation for assessment of 9,710,088 square feet of buildings at a total cost of $2,201,120. The two TDH hospitals join TDMHMR campus and are joined by sharing utilities and physical therapy and staff training.

TDH indicated an interest to be a partner in the CAFM program at the South Texas Hospital and Texas Center for Infectious Disease. The physical plants are joined by utilities and by physical buildings. Joint use of the facilities would be a benefit to both agencies. Joint CAD drawings, buildings and physical infrastructures would be beneficial. HCR 129, 74th Legislature, required TDH and TDMHMR to ascertain costs for constructing or renovating buildings in order to achieve maximum benefit from co-location.

Bexar County also has an interdisciplinary work project currently involved in analyzing and assessing programs and facilities needed for mental health and mental retardation services into the 21st century. This project has site significance to TCID because San Antonio State Hospital and State School provide significant percentages of their services for Bexar County residences. Any fundamental change to these programs affecting services, facilities and/or staffing potentially affects TCID. Findings and recommendations are not anticipated until late-1998 or early-1999.

Future Development of Regional Hospitals For TB

The effective treatment of every case of tuberculosis is essential to prevent the spread of TB to uninfected individuals as well as prevent the development of multidrug resistant strains, which may cause increased morbidity, as well as up to 50% mortality. Utilizing widespread DOT has led to the lowest rates of TB as well as a dramatic decrease in resistant strains. However, a recent report from Denver, a city with a TB Control program which was instrumental in the introduction of DOT and has been its foremost proponent, showed that noncompliance with DOT was common (18%) and was closely associated with alcoholism and

homelessness. Noncompliance with DOT was associated a 10-fold increase in the occurrence of poor outcomes from treatment and accounted for most treatment failure.

Another recent study from California showed 1-2% of adult TB patients are repeatedly nonadherent to traditional outpatient therapy, including DOT. Among those recalcitrant TB patients, a majority (81%) had drug or alcohol abuse, 46% were homeless, and 28% had mental illness which made traditional outpatient therapy virtually impossible. However, after detention, 84% of these TB patients successfully completed therapy. These data closely mirror the Texas experience.

In addition to nonadherent patients, TB patients with complicated medical or psychosocial problems pose a threat to public health because of possible inadequate TB treatment. In those cases, hospitalization, or detention in case of nonadherence, may be a necessary component of a comprehensive TB control program for the purpose of completing appropriate therapy for TB. It has been shown that a high proportion of patients with TB who failed outpatient therapy completed treatment in a combined medical and psychosocial inpatient unit. Improvements in the care of persistently nonadherent TB patients seems to require the availability of more psychosocial services, appropriate facilities for civil detention, and the ability to detain patients long enough to assure completion of treatment, while protecting the patient's as well as the community's civil liberties.

Under the auspices of the National TB Controllers Association, a nationwide survey, in which a questionnaire was sent to the different State TB Controllers around the US, was used to determine the number of individuals that needed long-term hospitalization to complete TB therapy, as well as how many areas had the necessary facilities to care for individuals who are unable to be cured by traditional outpatient therapy. An analysis of the survey revealed that in 1996, an average of 6.7 patients per state were involuntarily admitted to a hospital or other facility due to failure to complete therapy as an outpatient. Within the past year, 36 states invoked their own current laws, which allow the health department to control the spread of TB through compulsory examination and treatment. Only 27 states have access to a facility for the long-term admission of TB patients. Only a few of these institutions had the comprehensive level of care needed to assure a cure in the most difficult patients. In areas without these institutions, many times facilities not fully equipped to care for such patients such as jails, acute care and/or mental hospitals were utilized. The estimated cost for the institutionalization ranged between $30-$2000/day.

A significant number of state TB controllers indicated in the survey that they had the need to utilize long-term hospitals for the treatment of TB patients. However, due to the small number of such cases in most areas, many states could not maintain specialized TB facilities to treat patients with complex medical/psychosocial problems. In the survey, 13 states would be able to accept recalcitrant TB patients from other states if interstate legal issues and reimbursement mechanisms could be arranged. Excluding these 13 states, 30 of 35 states said they would consider utilizing such a regional hospital out of state. Given the needs of many states but the limited available resources, options are being evaluated for publication, assessment and proposals to CDC for a plan to explore the possible development of regional hospitals for

recalcitrant TB patients. Those proposals are anticipated in 1999 or 2000 for followup through CDC or some other federal of state source.

NAFTA Implementation

The development of the NAFTA corridor will provide easier access for traffic between South and Central America, Mexico, and the United States. Only seven major commercial points of entry links Mexico with the U.S.: two in California, one in Arizona, and four in Texas. Geography essentially binds the countries to these traditional points. One transportation option, the extension of I-69 to add 1,800 miles of interstate roads, would link with two of the commercial centers, McAllen (US 281) and Brownsville (US77). I-69 is anticipated to consist of two congressionally designated "High Priority Corridors" of national significance: High Priority Corridor 18, an extension of I-69 from Indianapolis to Evansville, Memphis, Shreveport, Houston and the Rio Grande Valley in Texas; and High Priority Corridor 20, consisting of US 59 from Texarkana to Houston and Laredo. The combination of these two corridors would make a single route stretching from Port Huron, Michigan, adjacent to Canadian population and industrial centers, to Laredo and the Rio Grande Valley at the Texas/ Mexico Border and on to the population and industrial centers in Mexico. Under terms of the North American Free Trade Agreement (NAFTA), Canada, the United States and Mexico will comprise the largest free trade zone in the world with 360 million consumers and a combined annual output of $6 trillion.

Some economists predict that by the year 2000, United States exports to Mexico will increase by as much as 70 percent, while Mexican exports to the United States may grow by as much as 120 percent. Currently, 70 percent of all trade between the United States and Mexico is transported via truck.

This increased flow will also allow more access to the transmission of disease. Funding for major highways, improved communications, and new border crossing procedures are in the development process to improve the exchanges of products and services. Traffic flows, travel efficiencies, bottleneck reduction, and improved transportation management will allow greater freedom at border crossing points. Improved transportation and communication infrastructure all along the NAFTA corridor are anticipated to enhance opportunities from movement which have not previously been possible. At the same time, transmission opportunities for communicable diseases are also anticipated to be enhanced with population movement. Much further study is indicated to assess the potential for more serious public health concerns due to infrastructure improvements anticipated as NAFTA accords are implemented.

Brooks AFB - San Antonio

Brooks Air Force Base is located immediately across from TCID. While avoiding the last federal Base Relocation Advisory Commission's report for base closure during the last three years of its work, Brooks AFB has opened an evaluation office and begun working with the Greater San Antonio Chamber of Commerce to assess integrated business opportunities with the community. Efforts are currently underway to prioritize the base's assets with the goal of leasing out those facilities and spaces that are underutilized to further solidify the community-federal linkage.

No facilities are available at Brooks AFB that would seem to lend themselves for direct patient care. There is laboratory capacity for research work. A 6,000 square foot clinic facility is currently in use. There is a cardiac catheterization laboratory and small ICU that is currently used as administrative areas. Further federal use is anticipated for all these facilities other than research, where possibilities for joint venturing may be pursued.

Optional Medicaid eligibility class for TB-infected persons.

Implementation of this option would be complex for several reasons; however, pursuing the option could provide for additional federal funding for the benefit of Texas. To the extent that Medicaid can cover costs currently provided by either the State or local governments, there should be a net benefit for Texas.

OBRA 93 legislation provides that states can offer certain Medicaid services to TB infected persons who additionally meet all of the State's other Medicaid categorical eligibility requirements. The coverage "... includes services (other than room and board) that are designed to encourage completion of regimens of prescribed drugs by outpatients, including services to observe directly the intake or prescribed drugs."
Note: This option is solely for outpatient care.

The federal definition for TB-infected person states, "An individual is considered infected with TB if the individual is either infected with latent or active tuberculosis, has a positive TB skin test, or has a negative tuberculin test, but a positive sputum for the TB organism. In addition, an individual whose TB test is negative, but whose physician's certification indicates the individual requires TB-related drugs and/or surgical therapy can be considered TB infected for purposes of this section. The physician's judgment that the person requires testing to confirm the presence (or absence) or the TB organism also meets qualification as infected with tuberculosis."

The lack of utilization data regarding State-provided services to potentially eligible persons as well as services provided by local governments make a definitive fiscal estimate impossible at this time. Another complicating factor for the Texas Department of Human Services is the lack of a means to quantify the numbers of individuals that would meet eligibility requirements and would avail themselves of that possibility; consequently, it is impossible for the agency to accurately project Medicaid budget implications. Projected annual TB statistics do provide some gross parameters on the eligibility group: annual estimates of approximately 2,000

persons with TB and 20,000 with positive TB skin reactions; however, there is not an accurate method to project the number of individuals, especially among the 20,000 who would become Medicaid eligible and actually apply for these benefits.

It should be noted that this option, if adopted, would be a statewide requirement. Therefore, it could provide federal Medicaid funding for cases currently served by TDH, county and city hospital districts and private hospitals that are now funded by a variety of other funding sources.

Additionally, when TDH previously considered this option, they encountered major impediments with regard to the TDHS SAVERR data base which is the host for Medicaid eligibility records. The year 2000 and a host of other programming requirements, TDH's cost projections, and implementation time line heavily contributed to a decision not to implement the option.

Provided TDH and TDHS can assemble the necessary information for preparing a fiscal note, it is recommended that an alternate eligibility data base methodology be considered. Based on preliminary discussions with HCFA, it appears a PC data base could be developed and maintained by TDH to manage the eligibility for this group. This approach would require TDH to also do the eligibility determinations, but the process would be managed through existing systems.

Strategies for continued recruitment, training, and retention of competent staff

At both STH and TCID, recruitment, training and retention of competent staff has been a priority for the TDH management. Management has prioritized the need for clinical staff to maintain their credentials and competence in each of the hospitals. As previously noted all but two of the physicians are board certified in their practice specialties.

Hospital attendant staff turnover is not considered a problem at either facility at this time according to TDH management, except in critical professional nursing and medical staff positions at STH which are part of that region's overall concern as evidenced by continued efforts to enhance regionalized professional educational opportunities in the Valley.

Strategies for Medicaid managed care at the hospitals

A review of the admissions by payer type indicates there are relatively few Medicaid admissions at both TDH hospitals. Considerations should be given the public health risks of TB in deciding whether to force Medicaid patients with TB into a managed care plan. Consequently, TB services should be continued as a carve-out category for managed care, remaining under a fee-for-service system instead of a capitated managed care system.

Campus coordination with TDMHMR regarding co-location

As previously discussed, both the STH and TCID share campuses with TDMHMR programs and also share selective support services. It should be noted that the STH land belongs to TDH and TCID land belongs to TDMHMR. Therefore, options involving any potential closure and management change must involve TDMHMR to assure that management and cost implications are considered at TDMHMR. If STH closes, the impact on Rio Grande State Center will include:

- **staff to operate the steam plant five days per week**
- **staff to operate the laundry plant five days per week**
- **staff to operate the central kitchen seven days per week**

If TCID closes, the impact to San Antonio State School will include:

- **staff to operate the steam plant seven days per week**

TCID and STH Laboratories

Services provided at both TDH hospital's campuses include a number of laboratory activities that require consideration as renovations, reconfigurations, closure and/or management changes are considered.

TDH is currently conducting an internal review process through which it is considering all of the agency's laboratory management. The outcome of this process will be relevant to the long term structure, location, and management of these services.

The TCID and STH clinical laboratories are integral to and inseparable from the respective hospitals. However, the Women's Health Laboratory at TCID, the Research Laboratory at TCID, and clinical and reference laboratory services in both hospitals are potentially separable from the hospital functions. Consequently, any one or all of these could be arranged in conjunction with the various options presented. The chief consideration is to assure that these important laboratory functions experience no disruption or erosion of support and, preferably, are administered under a consolidated management strategy.